PRINTED: 12/16/2008 **FORM APPROVED** Bureau of Licensure and Certification (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 12/09/2008 NV\$214AGC STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **4089 E BOSTON AVENUE GOOD SHEPHERD REST HOME 4** LAS VEGAS, NV 89104 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE ID (X4) iD (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Y 000 Y 000 Initial Comments This Statement of Deficiencies was generated as a result of the annual state licensure survey conducted at your facility on 12/9/08. This survey was conducted using Nevada Administrative Code (NAC) 449, Residential Facility for Groups Regulations, adopted by the Nevada State Board of Health on July 14, 2006. The facility was licensed for 6 Category 1 beds. The facility had an endorsement to care for elderly or disabled persons and/or persons with mental illnesses. The census at the time of the survey was six. Six resident records were reviewed. One closed record was reviewed. Three employee files were reviewed. There were no complaints investigated during the survey. RECEIVED The findings and conclusions of any investigation JAN 0 5 2009 by the Health Division shall not be construed as prohibiting any criminal or civil investigations, BUREAU OF LICENSURE AND CERTIFICATION actions or other claims for relief that may be LAS VEGAS, NEVADA available to any party under applicable federal.

Y 070 449.196(1)(f) Qualifications of Caregiver-8 hours SS=F training

The following regulatory deficiencies were

Y 070

NAC 449.196

identified:

state, or local laws.

1. A caregiver of a residential

facility must:

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

dministrator

(X6) DATE

1-0

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

PRINTED: 12/16/2008 FORM APPROVED Bureau of Licensure and Certification STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING B. WING NVS214AGC 12/09/2008 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **4089 E BOSTON AVENUE GOOD SHEPHERD REST HOME 4** LAS VEGAS, NV 89104 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID. (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) Y 070 Continued From page 1 Y 070 (f) Receive annually not less than 8 hours of training related to providing for the needs of the residents of a residential facility. This Regulation is not met as evidenced by: Based on record review, the facility failed to Y070 ensure not less than eight hours of training related to providing for the needs of the residents had been received annually by 3 of 3 employees. a) After the survey, the 3 employees were scheduled Findings include: to attend a training for persons with mental illness. Employee #1 was hired as the administrator on They attended the training 12/1/94. on Dec. 29 - 30, 2008. The file for Employee #1 lacked documented All employees files evidence of eight hours of training for mentally ill will be reviewed at least persons for the past year. ¢very 6 months to ensure completion of the CEU Employee #2 was hired as a caregiver on The adminisrequirements. 9/15/08. trator will monitor for the compliance. The file for Employee #2 lacked documented evidence of eight hours of training for mentally ill c) Attachment #1. persons. Employee #3 was hired as a caregiver on d) 1 - 3 - 09. 12/1/94.

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

The file for Employee #3 lacked documented evidence of eight hours of training for mentally ill

Scope: 3

Y 108 449.200(3) Per File - Storage & Availability

persons for the past year.

Severity: 2

SS=F

Y 108

RECEIVED

JAN 0 5 2009

BUREAU OF LICENSURE AND CERTIFICATION

LAS VEGAS, NEVADA

PRINTED: 12/16/2008

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Bureau o	of Licensure and Ce	rtification					
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		A. BUILDIN		(X3) DATE SU COMPLE	
NVS214AGC		NVS214AGC	B. WING			12/09	9/2008
NAME OF P	ROVIDER OR SUPPLIER		STREET ADI	ORESS, CITY,	STATE, ZIP CODE		
GOOD S	HEPHERD REST HO	ME 4		OSTON AVI AS, NV 891			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
Y 108	Continued From pa	age 2		Y 108			
	NAC 449. 200 3. The administrator may keep the personnel files for the facility in a locked cabinet and may, except as otherwise provided in this subsection, restrict access to this cabinet by other employees of the facility. Copies of the documents which are evidence that an employee has been certified to perform first aid and cardiopulmonary resuscitation and that the employee has been tested for tuberculosis must be available for review at all times. The administrator shall make the personnel files available for inspection by the bureau within 72 hours after the bureau requests to review the files.				a) After the survey, Employee #1 did the annual TB symptoms check for employee #2. She is due for her next annual TB and physical exam on 2-7-09 Employee #1 ensures that it will be done before the due date. b) Employees files will be audited at least every 6 months to ensure employee with negative chest X-rays results be screened for TB symptoms before their annual TB and physical. The administrator will monitor the compliance.		s
	This Regulation is not met as evidenced by: Based on record review and interview, the facilit failed to ensure annual Tuberculosis (TB) screening had been completed for 1 of 3 employees (#2).				c) Attachment #2 d) 1-3-09	•	
	Findings include:				RE	CEIVED	
	Employee #2 was 9/15/08.	hired as a caregiver	on		JA	N 0 5 2009	
	a negative chest x	yee #2 contained evi -ray completed 2/7/0 ented evidence of TE	7. The			ICENSURE AND CERTIFICATI AS YEGAS, NEVADA	

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

screening for the past year.

PRINTED: 12/16/2008 FORM APPROVED

Bureau of Licensure and Certification

STATEMENT	OF	DEFIC	IENCIES
AND PLAN OF	E CC	TRREC	CTION

NAME OF PROVIDER OR SUPPLIER

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION			
A. BUILDING			
D MINC			

(X3) DATE SURVEY COMPLETED

12/09/2008

NVS214AGC

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GOOD SHEPHERD REST HOME 4

STREET ADDRESS, CITY, STATE, ZIP CODE

4089 E BOSTON AVENUE LAS VEGAS, NV 89104

GOOD SHEPHERD REST HOME 4		LAS VEGAS, NV 89104				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (X (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
Y 108	Continued From page 3	Y 108				
	Severity: 2 Scope: 3					
Y1010 SS=C	449.2764(1) MI Training	Y1010				
	NAC 449.2764 1. A person who provides care for a resident of a residential facility for persons with mental illnesses shall, within 60 days after he becomes employed at the facility, attend not less than 8 hours of training concerning care for residents who are suffering from mental illnesses.		Y1010 a) Employee #1 had her training for persons with mental illness on 12-30-08. Her file is now updated.			
	This Regulation is not met as evidenced by: Based on record review, the facility failed to ensure not less than eight hours of training was received within 60 days after employment by 1 of 3 employees (#2).		b) Employee #1 will ensure that training for persons with mental illness be done and documented with 60 days from date of hire. The administrator is responsible for the practise.			
	Findings include:		c) Attachment #3.			
	Employee #2 was hired as a caregiver on 9/15/08.		d. 1-3-09.			
	The file for Employee #2 lacked documented evidence eight hours of training for mentally ill persons since 9/15/08.		RECEIVED			
	Severity: 1 Scope: 3		JAN 0 5 2009			
			BUREAU OF LICENSURE AND CERTIFICATION LAS YEGAS, NEVADA			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.